

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>101018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/06/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>OAKLAWN HEALTH &amp; REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 SHELBY STATION DRIVE</b> <b>LOUISVILLE, KY 40245</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	<p>INITIAL COMMENTS</p> <p>A Complaint Survey was initiated on 03/03/15 and concluded on 03/06/15 to investigate KY 22911. The Division of Health Care unsubstantiated the allegation with no deficiencies cited.</p>	N 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE